OXNARD FAMILY CIRCLE
ADULT DAY HEALTH CARE CENTER
**2100 Outlet Center Dr. #380, OXNARD, CA 93036**
**Phone: (805) 385-4180 FAX: (805) 751-4149**

# Physician's Authorization/ Participant's Physical and History

**(could be returned by fax: 805-751-4149 or email: enrollment@oxnardfamilycircle.com)**

| | |
|---|---|
| Patient Name: | Telephone: |
| Address: | Female ☐ Male ☐ |
| City/State/Zip | Age: DOB: |

***TB Clearance** (within the last 12 months): *Required prior to Patient attending the ADHC****

Date of test: _____ ☐ Negative ☐ Positive

Method: ☐ PPD Test ☐ Chest X-Ray

I approve an order for the RN to administer a PPD test at the ADHC: ☐ Yes ☐ No

**Any indication of communicable disease: ☐ Yes ☐ No**

## Current Medical Exam (Print Out of the Current Medical Exam could be used instead)

| Wt: | Ht: | Temp: | Pulse: | BP: |
|---|---|---|---|---|
| HEENT | Lungs | **Primary DX (DX & Meds Print-Out could be used instead): DX & Meds Print-Out attached** ☐ Yes ☐ No | | **ICD9** |
| Mouth | Heart | | | |
| Thorax | GI | | | |
| Breast | Genitourinary | **Secondary DX:** | | |
| Lymphatics | Musculo-skeletal | | | |
| Other | Rectal | | | |

**ALLERGIES?** ☐ No ☐ Yes _____

**PROGNOSIS:** Excellent/Good/Fair/Guarded/ (circle one)

**DIET AND NUTRITION:**

☐ Prudent/Diabetic (low fat, low cholesterol, low sodium, high fiber, NCS) ☐ Puree ☐ Chopped

☐ Renal (low potassium, low phosphorous, low sodium, limited protein)

☐ Other _____

**SPECIAL ORDERS:**

Glucose Testing: (<60, >350 mg/dl) ☐ Yes ☐ No Frequency: ☐ Daily ☐ Weekly ☐ Other: _____

BP Check (<90/60->180/100) ☐ Yes ☐ No Frequency: ☐ Weekly ☐ Other: _____

Oxygen Therapy: 2/L per minute per nasal canula PRN SOB Continuous Other _____

Other: _____

**Requested Services: ___RN ___OT ___PT ___Social Work ___Registered Dietitian ___Speech Therapist ___Podiatrist ___Psychological Services**

**PRN ORDERS while at the center:**

**Pain**
- ☐ Advil (200mg), 2 tablet, Q 4 hours with food
- OR ☐ Tylenol 500 mg, 2 tablets, Q 6 hours
- OR ☐ Other: _____

**Stomach upset/ Intestinal distress:**
- ☐ Laxative (M.O.M.), 30cc, PRN for constipation
- ☐ Kaopectate, 2 tablets, PRN for diarrhea
- ☐ Antacid, 30cc or 1 tablet, Q 4 hours
- ☐ Pepto Bismol, 30ml, q 30-60 mins, prn diarrhea

**MD Signature**_____ Date_____

# Medication Profile

**Med Profile Print-Out could be used instead: Med Profile Print-Out is attached** ☐ Yes ☐ No

Participant Name: _____

| Date Ordered | Medication & Dosage | Route | Frequency | Diagnosis |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

I agree that a registered nurse, occupational therapist, physical therapist, social worker and recreational activity coordinator will assess my patient. A registered dietician, speech therapist, podiatrist and psychological consultant may provide care if a need is identified by the multidisciplinary team. A plan of care will be developed, under which care will be provided for the next 6 months. The therapeutic goal is for my patient's level of function to be maintained or improved. I agree that my patient meets the criteria set by CA Code of Regulations Title 22 for attendance in an ADHC program. This requires that there is a medical condition requiring the treatment or rehabilitative services ordered by an MD; a mental or physical impairment which handicaps daily living but not requiring 24 hour institutional care; and a high potential of deterioration and probable institutionalization if ADHC care is not provided.

**I APPROVE OF MY PATIENT ATTENDING OXNARD FAMILY CIRCLE ADHC PROGRAM:**

| Physician Signature: | Date: |
|---|---|
| | |

OXNARD FAMILY CIRCLE
ADULT DAY HEALTH CARE CENTER

# HIPAA Privacy Authorization Form

**Effective Date: _____**

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Pans 160 and 164)

**1. Authorization.** I, _____, authorize _____ to use and disclose to protected health
**(name of healthcare provider)**
information described below to a business entity known as Oxnard Family Circle ADHC.

**2. Effective Period.** This authorization for release of information covers all past, present, and future periods of health care.

**3. Extent of Authorization.** I authorize the release of my complete health record (including records related to mental healthcare, communicable diseases, HIV or AIDS, treatment of alcohol or drug abuse).

**4. Use.** This medical information may be used by the entity I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

**5. Termination.** This authorization shall be in force and effect until the date of _____, at which time this authorization form expires.

**6. Revocation Rights.** I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

**7. Benefits.** I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

**8. Disclosure.** I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

**Participant's Name _____Signature _____**
(or **Personal Representative**)

**Date _____**